



## Communicable Disease and Epidemiology News

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### The Medical Monitoring Project (MMP)

MMP is a CDC-sponsored expanded HIV/AIDS surveillance project that will be starting in King County and Washington State later this summer. MMP will examine HIV-related presentation and outcomes. MMP has a three stage random selection process starting with selection of states (Washington was included among the 20 states selected), followed by medical providers, and then patients. This process is designed to ensure that a scientifically representative, population-based cohort of patients is selected.

Data will be collected by medical record review and patient interview. Medical record review data include HIV-related treatments, diagnoses, and laboratory values. The interview asks patients about their health-care seeking and other behaviors impacting HIV care, such as adherence to HAART. Some of the goals of MMP are to:

- help health and prevention planners estimate how many people are receiving care for HIV
- determine barriers to care
- examine morbidity still experienced by HIV-infected persons in the HAART-era
- measure adherence to, acceptance of, and adverse effects of therapy

If you are a provider and your site is selected for MMP, we encourage you to participate. It is essential that all selected providers participate as providers will be selected to represent many other providers that have similar characteristics.

If you would like more information about this project please contact Elizabeth Barash with the HIV/AIDS Program at (206) 296-2907.

### 2003 Nationwide Hepatitis A Incidence at a 40-Year Low

A recent article by Wasley, et al in the Journal of the American Medical Association<sup>1</sup> described the changing incidence and epidemiology of hepatitis A in the United States from the pre-vaccination era (1990-1997) to 2003.

Since surveillance began approximately 40 years ago, hepatitis A incidence in the US has followed a cyclical pattern, with peaks and nadirs typically occurring every ten years; the use of hepatitis A vaccination may have interrupted this cyclical pattern. Between the pre-vaccination baseline period (1990-1997) and 2003, the incidence of hepatitis A, 10.7 per 100,000 and 2.6 per 100,000 respectively, decreased 76 percent. In addition,

the 2003 incidence rate was the lowest recorded in 40 years of surveillance, and was significantly lower than rates during the two previous nadirs of 9.2 /100,000 in 1983, and 9.1/100,000 in 1992. The provisional hepatitis A incidence rate for 2004 is even lower, at 1.9/100,000.

In order to evaluate the role that hepatitis A immunization may have played in these trends, Wasley, et al, compared the incidence of hepatitis A in states that had instituted recommendations to vaccinate, or to consider vaccinating children with hepatitis A vaccine, to states that did not. During the pre-vaccination baseline period (1990 to 1997), the hepatitis A incidence rate in the “vaccinating” states was four times higher than the rate in the “non-vaccinating” states. By 2003, however, there was no significant difference in the rates between vaccinating and non-vaccinating states.

#### Hepatitis A Trends in King County

The same declining trend in national hepatitis A incidence rates has also occurred in King County. During the pre-vaccination baseline period (1990 to 1997), the average incidence of hepatitis A was 20.9 per 100,000; in 2003 the rate was 1.68 per 100,000 and in 2004 the rate was 0.8 per 100,000.

The hepatitis A vaccine was licensed in 1995. Beginning in 1997, the vaccine was recommended for high-risk children age two through eighteen years residing in King County. In 2000, hepatitis A vaccination was recommended for all children age two through eighteen years.

#### In the US, Hepatitis A vaccine is currently recommended for:

- All children 2 through 18 years of age.
- Gay and bisexual men.
- Illicit drug users (injecting and non-injecting).
- International travelers to areas where hepatitis A is common:
  - includes all areas of the world *except* Canada, Western Europe, Scandinavia, Japan, New Zealand, and Australia.
- Persons with chronic liver disease, including chronic hepatitis B and hepatitis C.
- Persons with clotting factor disorders, such as hemophiliacs.
- Anyone else who wants protection against hepatitis A.

<sup>1</sup>Wasley A, Samandari T, Bell B. Incidence of hepatitis A in the United States in the era of vaccination. *JAMA* 2005;294:194-201.

Campylobacteriosis Outbreak Associated with a Camping Trip to a Farm

In June 2005, a King County health care professional (HCP) reported to Public Health that a child presenting with diarrhea, abdominal pain, and fever had been on a camping trip with his/her school prior to becoming ill. The family also reported that several other persons on the trip had been ill with similar symptoms following the trip. A stool specimen was collected for culture and *Campylobacter* was isolated. The same week, two more case of campylobacteriosis were reported in persons who had been on the same camping trip, held at a private farm. An outbreak investigation was initiated.

Of the 28 persons attending the camping trip (5 adults and 23 students), 14 (50%) reported having had symptoms consistent with campylobacteriosis following the trip. A total of four laboratory confirmed cases of campylobacteriosis were eventually reported in trip participants.

There were several animals at the farm (and an adjacent farm), including chickens, cows, turkeys, and goats. Environmental specimens were collected from animal areas and drinking water; all tested negative for bacterial pathogens, including *E. coli* O157:H7, *Salmonella*, and *Campylobacter*. One of three water samples collected was positive for fecal coliforms, though this was not the usual source of water for the campers. Possible sources of infection were discussed with the farm owners and the school, and education was provided on measures to prevent infections associated with animals, including *E. coli* O157:H7, *Salmonella*, and *Campylobacter*.

Although no single source for the illnesses was identified by the investigation, several high-risk activities and food items that have been previously associated with *Campylobacter* infection were identified, including consumption of unpasteurized dairy products, and direct and indirect contact with farm animals, and animal manure. Inadequate handwashing facilities and inadequate handwashing supervision likely exacerbated these risks.

During spring and summer, when visits to farms, petting zoos, and local fairs are on the increase, HCPs should inquire about recent direct or indirect contact with animals, or animal manure among patients (especially children) who present with acute gastroenteritis so that

testing for bacterial infections (and other types of infection, including parasitic), can be initiated. Report suspect or confirmed infections with *E. coli* O157:H7 or *Salmonella* immediately, and confirmed cases of campylobacteriosis within three days to Public Health. Report suspected clusters of illness to Public Health immediately.

*Special thanks to David Ramaley, ND, DC, for initially reporting this cluster of illness to Public Health.*

Spokane Woman Tests Negative for West Nile Virus

On July 18<sup>th</sup>, the Washington State Department of Health announced that a Spokane woman, who had initially tested positive for West Nile Virus, has tested negative after additional tests. There have still been no cases of West Nile virus infections identified in horses, bird or humans this year in Washington State. One human case was reported in a Washington state resident in 2004, but that person was traveling in areas where West Nile Virus infection was occurring during his/her exposure period.

For West Nile Virus updates and current testing guidelines see: [www.metrokc.gov/health/westnile/advisories.htm](http://www.metrokc.gov/health/westnile/advisories.htm)

**Disease Reporting**

AIDS/HIV.....(206) 296-4645  
STDs.....(206) 731-3954  
TB .....(206) 731-4579  
All Other Notifiable Communicable Diseases (24 hours a day)..... (206) 296-4774  
Automated reporting line for conditions not immediately notifiable..... (206) 296-4782

**Hotlines**

Communicable Disease.....(206) 296-4949  
HIV/STD.....(206) 205-STD5

**Public Health-Seattle & King County Online Resources**

Home Page: [www.metrokc.gov/health/](http://www.metrokc.gov/health/)  
The **EPI-LOG**: [www.metrokc.gov/health/providers](http://www.metrokc.gov/health/providers)  
**Communicable Disease listserv (PHSKC INFO-X) at:** [mailman.u.washington.edu/mailman/listinfo/phskc-info-x](mailto:mailman.u.washington.edu/mailman/listinfo/phskc-info-x)

Reported Cases of Selected Diseases, Seattle & King County 2005				
	Cases Reported in June		Cases Reported Through June	
	2005	2004	2005	2004
Campylobacteriosis	36	31	147	121
Cryptosporidiosis	7	1	47	12
Chlamydial infections	580	616	2,912	2,671
Enterohemorrhagic <i>E. coli</i> (non-O157)	0	0	4	0
<i>E. coli</i> O157: H7	3	2	11	11
Giardiasis	17	14	60	65
Gonorrhea	169	111	830	583
<i>Haemophilus influenzae</i> (cases <6 years of age)	1	0	2	2
Hepatitis A	4	2	12	5
Hepatitis B (acute)	2	0	13	14
Hepatitis B (chronic)	55	41	314	313
Hepatitis C (acute)	0	0	4	5
Hepatitis C (chronic, confirmed/probable)	104	56	644	620
Hepatitis C (chronic, possible)	37	25	230	176
Herpes, genital (primary)	157	82	409	376
HIV and AIDS (includes only AIDS cases not previously reported as HIV)	36	33	245	213
Measles	0	0	0	6
Meningococcal Disease	1	0	11	9
Mumps	0	0	1	0
Pertussis	32	16	134	116
Rubella	0	0	1	0
Rubella, congenital	0	0	0	0
Salmonellosis	24	27	110	104
Shigellosis	4	1	30	31
Syphilis	4	14	70	53
Syphilis, congenital	0	0	0	0
Syphilis, late	7	4	41	35
Tuberculosis	15	19	57	67

The *Epi-Log* is available in alternate formats upon request.